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NEVER LET YOUR SENSE OF MORALS KEEP YOU FROM DOING WHAT'S RIGHT: USING NEWLY DEAD BODIES AS EDUCATIONAL RESOURCES

Dale L. Moore[†]

*"I take it to be self evident that there can be no experienced physicians unless, at some point, procedures are done by inexperienced persons. The question, therefore, is not whether students should use patients for practice, but under what guidelines."*¹

INTRODUCTION

A. A Scenario to Consider

Paramedics transported a sixty-year-old man who was experiencing crushing chest pain to the emergency room at University Hospital. Shortly thereafter the patient's cardiac and respiratory function ceased on account of the massive heart attack that caused his chest pain. The emergency-room team administered standard resuscitation measures, including endotracheal intubation, the insertion of a tube into his windpipe to establish an airway; assisted ventilation, the pressurized delivery of air to his lungs via the endotracheal tube to enable oxygenation of his vital organs; and insertion of a central intravenous line, the placement of a catheter into a large vein near his clavicle for delivery of fluids and medications. Despite vigorous effort, the team was unable to restore the patient's heart or lung function. About an hour after the patient's arrival at the emergency room, the physician leading the resuscitation team pronounced him dead.

Two of the health-care professionals who observed these events are continuing their formal educations. The first, a registered nurse, aspires to become a Certified Registered Nurse Anesthetist ("C.R.N.A."), and to that end is pursuing a master's degree in the

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¹ Earl E. Shelp & Norman Fost, *Case Study: Practicing Procedures on Dying Children*, 10 HASTINGS CTR. REP., August 1980, at 11, 12.

University's nurse anesthesiology program. While earning the degree, and after completing the program, the nurse will regularly perform endotracheal intubation. The second professional, a medical doctor, aspires to become board certified in emergency medicine, and to that end has recently begun a multi-year emergency-medicine residency program at University Hospital. During the residency and after its completion, the physician will frequently be called on to insert central intravenous catheters. Both professionals will perform these procedures on patients who are in extremis, when time is of the essence; confidence and skill will be critical to their success. At this point, however, these health-care professionals are novices. Both have observed others performing these procedures but neither has performed them herself. Is it appropriate for them to spend a few minutes practicing these two essential procedures on a newly dead body in the emergency room?

B. Brief Analysis of the Question Presented

The last decade has seen a fair amount of commentary² reconsidering a long-standing aspect of the education of health-care professionals: the use of newly dead bodies to teach novice professionals to perform medical procedures.³ Several medical professional organizations have lately condemned this practice, at least when it occurs without the express consent of the decedent, or his next-of-kin.⁴

² E.g., The Council on Ethical & Judicial Affairs of the Am. Med. Ass'n, *Performing Procedures on the Newly Deceased*, 77 ACAD. MED. 1212 (2002) [hereinafter AMA Council]; Mark W. Fourre, *The Performance of Procedures on the Recently Deceased*, 9 ACAD. EMERGENCY MED. 595 (2002); Kenneth V. Iserson, *Post-mortem Procedures in the Emergency Department: Using the Recently Dead to Practise and Teach*, 19 J. MED. ETHICS 92 (1993); Kenneth V. Iserson, *Teaching Without Harming the Living: Performing Minimally Invasive Procedures on the Newly Dead*, 8 J. HEALTH CARE L. & POL'Y 216 (2005) [hereinafter Iserson, *Teaching Without Harming*]; Alice Fleury Kerns, Comment, *Better to Lay It Out on the Table Rather Than Do It Behind the Curtain: Hospitals Need to Obtain Consent Before Using Newly Deceased Patients to Teach Resuscitation Procedures*, 13 J. CONTEMP. HEALTH L. & POL'Y, 581 (1997); Rumm M. Morag et al., *Performing Procedures on the Newly Deceased for Teaching Purposes: What If We Were To Ask?*, 165 ARCHIVES INTERNAL MED. 92 (2005); Kathleen S. Oman, John David Armstrong II & Martha Stoner, *Perspectives on Practicing Procedures on the Newly Dead*, 9 ACAD. EMERGENCY MED. 786 (2002); Terri A. Schmidt et al., *Ethics Seminars: The Ethical Debate on Practicing Procedures on the Newly Dead*, 11 ACAD. EMERGENCY MED. 962 (2004); Daniel Sperling, *Breaking Through the Silence: Illegality of Performing Resuscitation Procedures on the "Newly Dead,"* 13 ANNALS HEALTH L. 393 (2004).

³ Iserson, *Teaching Without Harming*, *supra* note 2, at 219 ("Many generations of physicians have learned and practiced lifesaving procedures in this manner.").

⁴ See Bd. of Dirs., Soc'y for Academic Emergency Med., *The Society for*

Commentary from the legal community, although less voluminous, concurs in the condemnation, which appears to derive from a belief that such nonconsensual educational activities are illegal. The potential bases for this belief would necessarily be 1) statutes, regulations, or other affirmative statements from sources authorized to define what is legal in this realm, or 2) case law stating that participants in these activities expose themselves to risks of civil liability, professional discipline, or criminal prosecution. Analysis of such potential bases, however, shows their insubstantiality.

Accordingly, in this article, I urge critics to reconsider their conclusions. Educational activities contemplated in the scenario above are not illegal, nor should they be made so. Until inventors create synthetic devices whose educational value equals that of newly dead bodies, we should encourage rather than condemn use of a unique resource that can no longer be helped or harmed.

Part I of this article reviews the background of this problem, explaining who cares about it, and why. Part II identifies flaws in the arguments advanced by proponents of a consent requirement and presents another perspective on the legal issues. Essentially, Part II explains why these educational activities are not presently illegal. Part III then makes the case for encouraging the activities, suggesting an approach limited to the emergency-care context, and setting forth the supporting legal analysis.

I. WHO CARES, AND WHY?

A. The Educational Use of Newly Dead Bodies

Aside from living human beings, newly dead bodies present the most realistic models available for allowing novices to acquire the skills they need to perform certain invasive procedures. Other potential models, such as animals, embalmed cadavers, and mannequins, do not provide suitable surrogates.⁵ Only an unembalmed human body

Academic Emergency Medicine Position on Procedures on the Newly Dead, 11 ACAD. EMERGENCY MED. 967, 967 (2004) (explaining the problems associated with performing these procedures without consent); AMA Council, *supra* note 2, at 1212-13; Lois Snyder & Cathy Leffler, *Ethics Manual*, 142 ANNALS INTERNAL MED. 560, 575 (2005) (functioning as a position paper for the Ethics and Human Rights Committee of the American College of Physicians); Schmidt et al., *supra* note 2 (discussing approaches of some "major medical associations").

⁵ Animal models may be less available than, and too dissimilar to, human bodies. Embalmed human cadavers lack the body fluids and lifelike qualities needed for realistic experiences. To the extent that they are available at all, mannequins and virtual reality programs are too expensive to be feasible for widespread use. Soc'y

that has not yet developed rigor mortis, the "stiffness of death," will do. Accordingly, for each professional who must learn these procedures, her first human subject will present a unique challenge. Should that first human subject be a living person, or a newly dead body? Put another way, should the valuable potential resource of a newly dead body go to waste or be put to good use?

Taking advantage of the opportunity to use a newly dead body to introduce a novice to techniques essential to her professional skills has been part of the world of medical education for many years.⁶ The activities involved are minimally invasive,⁷ if invasive at all, and of short duration. They cause no harm, they do not change the appearance of the corpse, and they do not interfere with bereavement or burial. Nonetheless, physicians and other health-care providers, as well as the organizations representing them, have raised questions about the legitimacy of such educational activities. The questions betray concern, perhaps even fear, about the consequences that could stem from these activities. Whether the potential consequences most feared involve professional liability, unpleasant publicity, or regulatory backlash is unclear. What appears quite clear, however, is that the reassessment summarized in recent commentaries has been driven in large part by a sense that there is something "wrong," or "bad" about these activities. Among the commentators from the professional medical community, the persuasive voice expressing a different view is that of a physician, Kenneth V. Iserson,⁸ whose clinical specialties are in emergency medicine and bioethics. He is virtually alone in rejecting the conclusion that a longstanding educational practice should be re-evaluated, and now determined a "bad" thing.

Commentary from the legal community has been comparatively sparse thus far and is best characterized as conclusory,⁹ or if more

for Academic Emergency Med., *supra* note 4. See also Richard K. Reznick & Helen MacRae, *Teaching Surgical Skills – Changes in the Wind*, 355 NEW ENG. J. MED. 2664, 2666-67, tbl. 2 (explaining that disadvantages of various simulation tools include anatomical differences [animals], compliance of tissues [human cadavers], limited technical applications [human performance simulators], and poor simulation of three dimensions [virtual reality simulators]; and that in general, "the higher the fidelity and the more realistic the model, the more expensive the training tool").

⁶ Iserson, *Teaching Without Harming*, *supra* note 2, at 219; my personal observations during a decade of critical-care experience as a registered nurse.

⁷ The characterization is Iserson's. See Iserson, *Teaching Without Harming*, *supra* note 2, at 216.

⁸ Iserson is a Professor of Emergency Medicine and Director of the Arizona Bioethics Program at the University of Arizona College of Medicine in Tucson.

⁹ See, e.g., Snyder & Leffler, *supra* note 4.

elaborate, not particularly persuasive.¹⁰ In general, it echoes the concerns raised by the medical-professional community, and condemns educational activities of the sort described above as, at least potentially, if not actually illegal.¹¹ In this article, I beg to disagree.

Although commentators from the medical community, whose writings are more substantial in quantity and analysis than those of the lawyers, have called for change, they have stopped short of suggesting complete abandonment of the educational opportunity afforded by a newly dead body. Instead, they urge the adoption of guidelines precluding educational use of newly dead bodies in the absence of express consent.¹² Requiring express consent, however, could so substantially reduce the availability of this resource as to effectively eliminate it.

B. An Ironic Contrast

Commentators' apparent fascination with questions about the propriety of using newly dead bodies for teaching is both disproportionate and ironic, given the relative dearth of attention to a much more problematic aspect of professional education: the use of living human beings as the pioneer victims for novices' training.¹³ A living patient about to become the subject of a resident physician's first attempt to insert a central intravenous line may not be told of the physician's lack of experience, let alone be given the opportunity to refuse her attentions in favor of a more proficient substitute's. This is not because the patient's family will have been asked to act as his surrogate. Rather, it is because no one will have been asked for specific consent to use this living patient as a pioneer victim. A focus on belabored discussion of a less troubling custom distracts our attention from the lack of emphasis on a more questionable one.¹⁴

¹⁰ See, e.g., Sperling, *supra* note 2; Kerns, *supra* note 2.

¹¹ See *supra* notes 9–10.

¹² AMA Council, *supra* note 2, at 1215.

¹³ For a timely discussion of the problematic aspects of this practice, see Winston Chiong, *Justifying Patient Risks Associated with Medical Education*, 298 J. AM. MED. ASS'N 1046 (2007).

¹⁴ The custom is questionable in part because of the potential for bad outcomes, as illustrated by courts' opinions describing the bad outcomes achieved when novice, or otherwise inexperienced professionals performed procedures on living patients. See, e.g., *Mullins v. Parkview Hosp., Inc.*, 830 N.E.2d 45, 50–51 (Ind. Ct. App. 2005), *aff'd in part & vacated in part*, 865 N.E.2d 608 (Ind. 2007) (The hospital-defendant permitted an E.M.T. student, who was pursuing a certification program, to practice her first human intubation on a patient who was under anesthesia for a hysterectomy. The student lacerated the patient's esophagus during two unsuccessful attempts to intubate the patient.); *Richard v. Colomb*, 916 So. 2d 1122, 1125 (La. Ct.

II. A TREND IN THE WRONG DIRECTION; CONSENT IS BESIDE THE POINT

Authority to establish a legal requirement that hospitals obtain express consent resides in familiar places: legislatures and administrative agencies, acting prospectively by creating statutes or regulations to this effect, and courts acting retrospectively, by imposing liability on those who have failed to obtain consent. These familiar entities have not created such rules in this area, however, so those who believe that consent is, or should be required, must draw on other sources or lines of reasoning.

Ostensible bases for requiring consent include: analogy to the rules governing other matters, such as the procurement of organs from cadavers; concern about interfering with the rights and interests of decedents' loved ones; and a rather uneasy and guarded intimation

App. 2005) (After surgery to remove a patient's gall bladder was "essentially complete," a physician member of the surgical team "took a stitch on otherwise healthy fatty tissue solely for the purpose of practicing his technique. . . . [S]titching was not a necessary technique or part of the operation" The needle was "lost" when the surgeon took the stitch.); *Felice v. Valleylab, Inc.*, 520 So. 2d 920, 923 (La. Ct. App. 1987) (A first-year resident performed a circumcision under supervision of a third-year resident using an electric cautery device that neither resident had been trained to use for circumcision surgery and that, in fact, was not customarily used for such surgery. Excessive electrical current from the device burned the child's penis severely, ultimately leaving him with no visible penile tissue.); *Dingle v. Belin*, 749 A.2d 157, 159 (Md. 2000) (A resident mistakenly clipped and dissected a common bile duct rather than a cystic bile duct when assisting with a laparoscopic cholecystectomy, causing "a great deal of pain" and a "need for extensive corrective surgery" at another hospital.); *Johnson v. Kokemoor*, 545 N.W.2d 495, 499 (Wis. 1996) (Surgery to clip a large basilar bifurcation brain aneurysm resulted in permanent neurological impairment. The surgeon had "relatively limited experience" with aneurysm surgery and virtually all of that experience was limited to the less complicated procedure to clip an anterior aneurysm.).

Furthermore, the custom of using living patients as "pioneers" is questionable because it is ethically problematic even in the absence of bad outcomes. See, e.g., Jennifer Goedken, *Pelvic Examinations Under Anesthesia: An Important Teaching Tool*, 8 J. HEALTH CARE L. & POL'Y 232 (2005); Robin Fretwell Wilson, *Autonomy Suspended: Using Female Patients to Teach Intimate Exams Without Their Knowledge or Consent*, 8 J. HEALTH CARE L. & POL'Y 240 (2005); see generally Janet L. Dolgin, *The Evolution of the "Patient": Shifts in Attitudes About Consent, Genetic Information, and Commercialization in Health Care*, 34 HOFSTRA L. REV. 137, 159-64 (2005) (discussing the importance of a physician's disclosure of his or her relative lack of experience in performing a particular procedure when obtaining a patient's "informed" consent to undergo that procedure at the hands of the relatively inexperienced physician).

that an individual's autonomy interest may survive his death, at least to some degree.¹⁵

The rationales accompanying the discussion by proponents of the consent requirement fail, however, to support the conclusion that the law requires express consent. First, statutes enacted to govern other matters do not speak to this issue, and interpretations that distort those statutes are not persuasive.¹⁶ Second, the legitimate concerns of interested parties receive sufficient protection without adding a consent requirement. Third, the courts' analyses of autonomy principles in treatment-refusal cases support the conclusion not only that consent is unnecessary, but also that refusal of consent may be ignored.¹⁷

A. Analogies to the Law Governing Related Issues

Analogies to the Uniform Anatomical Gift Act are inapt. Using a newly dead body for a brief teaching opportunity that takes nothing from the body and leaves its appearance unchanged is fundamentally different from harvesting body parts for transplantation. The physical invasion, if an invasion at all, is minimal, the procedure may well have already been performed during resuscitation efforts, and the duration is brief. By contrast, one may not procure transplantable organs

¹⁵ The consent proponents also mention their concern about undermining public trust in the medical profession. Since this concern does not give rise to discrete legal issues, I will explore it only to the extent it bears on the other points. A generalized concern about trust in the profession may stem from disapproval of any practice that even hints at disrespect for patients. For example, coping mechanisms that use gallows humor, which strike some as merely innocuous or irreverent, may lead others to conclude that the humor is crude and connotes disrespect for vulnerable patients. For an example of the use of gallows humor to cope with stressful situations, see SAMUEL SHEM, *THE HOUSE OF GOD* (1978) (describing a fictionalized account of the experiences of house staff in a teaching hospital). For a discussion of the objectionable implications of such coping mechanisms, see *WARD ETHICS: DILEMMAS FOR MEDICAL STUDENTS AND DOCTORS IN TRAINING* 154-70 (Thomasine K. Kushner & David C. Thomasma eds., 2001).

¹⁶ Although proponents from the medical community frame their remarks primarily in terms of "ethical" standards rather than legal principles, they invoke legal authorities such as the Uniform Anatomical Gift Act to support their position. See, e.g., AMA Council, *supra* note 2, at 1213 & 1216 n.17 (citing A. M. Sadler et al., *The Uniform Anatomical Gift Act: A Model for Reform*, 206 J. AM. MED. ASS'N 2501 (1968)) (explaining that the Uniform Anatomical Gift Act implies that family members of a recently deceased patient have "a legally recognized interest in how the remains of the body are to be treated"). Moreover, given the importance of industry custom in setting professional standards of care, expressions purporting to state a professional consensus will inevitably inform and influence legal analysis and reasoning.

¹⁷ That is, no one in the eligible population may "opt out." See *infra* note 46 and accompanying text.

without a physical invasion involving a procedure outside the scope of any treatment effort. Something must be “taken” from the body, an event absent from the teaching scenario.¹⁸ In addition, characterizing post-mortem intubation, venipuncture, or even pericardiocentesis as “mutilation” or “unauthorized autopsy” would constitute not only poor diction but also an unsupportable factual conclusion.¹⁹

B. Potential Interference with the Rights and Interests of Decedents’ Loved Ones

1. Legitimate Interests of Loved Ones

Prior to death, the physician owes a duty of care to the decedent, not his loved ones. This is true even in cases where loved ones must speak for a patient incapable of expressing his own wishes about treatment decisions.²⁰ The physician’s duty expires with the decedent; it does not migrate to his loved ones. The interests of loved ones are independent, and although entitled to respect, are neither unlimited nor absolute. Nor are they in jeopardy. Making use of the educational opportunity offered by a newly dead body will not impair the legitimate interests of the decedent’s loved ones, which, I contend, are limited to timely notification of the death, prompt opportunity to visit the decedent and view the remains, and unimpeded ability to take custody of the decedent’s body for burial and bereavement rituals. Loved ones’ legitimate interests do not include a property right in the decedent’s remains,²¹ or a right to deprive future patients of access to skilled professionals by thwarting a critical educational mission.

¹⁸ “Procurement” and “harvesting,” two terms used to characterize the obtaining of organs for transplantation, suggest their own meanings.

¹⁹ Reactions to body snatching and grave robbing have been driven by activities entirely distinct from those described here. For descriptions of body-snatching activities, see MARY ROACH, *STIFF: THE CURIOUS LIVES OF HUMAN CADAVERS* 37-57 (2003). For a fictionalized account of the gruesome practices of “resurrectionists,” see TESS GERRITSEN, *THE BONE GARDEN* (2007).

²⁰ For an especially poignant statement of this view, see John J. Paris, Robert K. Crone & Frank Reardon, *Physicians’ Refusal of Requested Treatment: The Case of Baby L*, 322 *NEW ENG. J. MED.* 1012 (1990).

²¹ See *infra* notes 22-23 & accompanying text. Cases in which liability questions of “unauthorized autopsy” arise are not implicated here. No one is making grotesque Y-shaped incisions through the chest and abdomen, or peeling away a scalp, or removing organs in part or whole.

2. Civil Liability Claims

Legal duties owed the decedent during life die along with him. His dead body cannot be the victim of battery, malpractice, or any other intentional or negligent tort. Potential claims based on educational use of the decedent's body, therefore, must be predicated on tortious behavior toward his survivors. And although the question whether a survivor owns a property interest in a corpse is sometimes explored,²² the essence of survivors' potential claims is personal injury, not property damage. Courts occasionally quote Professor Prosser on this point:

[In such cases], the courts have talked of a somewhat dubious "property right" to the body, usually in the next of kin, which did not exist while the decedent was living, cannot be conveyed, can be used only for the one purpose of burial, and not only has no pecuniary value but is a source of liability for funeral expenses. It seems reasonably obvious that such "property" is something evolved out of thin air to meet the occasion, and that it is in reality the personal feelings of the survivors which are being protected, under a fiction likely to deceive no one but a lawyer.²³

Whether categorized as unauthorized autopsy, or negligent mishandling of a corpse, the cases that might be germane basically boil down to claims that post-mortem wrongful conduct aggravated the emotional distress experienced by grieving survivors.²⁴ Accordingly, the appropriate question is whether educational use of a newly dead body is tantamount to actionable infliction of emotional distress to his survivors.

²² To the extent that a debate over the existence and scope of a survivor's "quasi-property right" in a decedent's body remains alive, it is beyond the scope of this article. Courts willing to entertain the possibility that such a right exists have made clear that human remains are of no financial value and have acknowledged that the real damage, if any, is to the feelings of the survivors. See *Bauer v. N. Fulton Med. Ctr.*, 527 S.E.2d 240, 245 (Ga. Ct. App. 1999); *Colavito v. New York Organ Donor Network*, 860 N.E.2d 713, 719 n.8 (N.Y. 2006).

²³ 5 PROSSER AND KEETON ON THE LAW OF TORTS 63 (W. Page Keeton ed., 5th ed. 1984). Pertinent portions of this quote were quoted in *Bauer* and *Colavito*, *supra* note 22.

²⁴ The so-called "bystander" cases are not relevant to this analysis. They deal with injuries that bystander-witnesses sustain on account of their observations of negligently caused injuries to their loved ones. See *infra* note 28.

a. Intentional Infliction of Emotional Distress (IIED) Claims

The stumbling blocks that stand in the way of an IIED claim's success are the requirements that a plaintiff prove both outrageous conduct and intent, two elements of an IIED plaintiff's *prima facie* case. Although satisfying the legal standard for proof of intent may be difficult,²⁵ the former of these two obstacles is the more formidable. Since recognizing the IIED tort claim,²⁶ courts have used a demanding definition of outrageousness, thereby keeping a tight rein on the expansion of this tort. To be outrageous, conduct must be truly indecent, shocking to the conscience, intolerable in a civilized society – "behavior that is so obnoxious, rude and gratuitously cruel as to go beyond all possible bounds of decency."²⁷ The "outrage" standard makes getting a case to the jury, which the conventional wisdom identifies as a tort plaintiff's goal, dauntingly challenging. Given this history, the idea that courts would be willing to treat a widespread, routine practice as potentially outrageous is simply not plausible.

b. Negligent Infliction of Emotional Distress (NIED)

Plaintiffs pursuing emotional distress claims based on a negligence theory also confront difficult, albeit somewhat different challenges. Like IIED plaintiffs, NIED plaintiffs must overcome courts' general reluctance to expand the scope of tort claims allowing compensation for purely emotional harm. For NIED plaintiffs, the doctrinal demands of a negligence theory, described below, augment the policy-based hesitation.

The first problematic aspect of an NEID claim lies in establishing the existence of a relationship on which the plaintiff might predicate a legal duty. The physician-patient relationship, which certainly gives rise to a legal duty, is limited to its parties and does not include survivors. On the occasions when courts have concluded that an existing physician-patient relationship imposed on the physician a duty to a third party, the third party has been at a foreseeable risk of personal injury due to the patient's ill-health, whether physical or mental. The educational practices under consideration here, however, create no

²⁵ The plaintiff must show that the defendant intended to cause severe emotional distress or, at the very least, recklessly disregarded the likelihood that his or her conduct would cause severe emotional distress. RESTATEMENT (SECOND) OF TORTS § 46 (1965).

²⁶ The earliest cases to recognize the claim were decided in the middle of the twentieth century. See, e.g., *State Rubbish Collectors Ass'n v. Siliznoff*, 240 P.2d 282, 285-86 (Cal. 1952).

²⁷ RICHARD A. EPSTEIN, TORTS § 1.8, at 18 (1999).

risks to third parties. Indeed, no actions at all need be directed toward third parties.²⁸

In the unlikely event that a newly dead body's survivor is able to establish duty, he will face the second demand of negligence doctrine: proof that the defendant breached that duty by failing to take reasonable care for the survivor's protection. Courts routinely defer to professional customs when they measure the reasonableness of health-care providers' behavior; in addition, given the complete absence of risk to a survivor, or any third party, the most appropriate question would be "Where's the breach?"²⁹

Finally, negligence law includes proof of damages as one criterion for establishing liability. Although proof of emotional harm will sometimes satisfy this criterion, it is by no means certain to be sufficient.

3. Other Forms of Liability

Survivors' complaints may provoke the initiation of professional disciplinary proceedings or criminal prosecutions. Such actions, pursued in the name, and on the behalf, of the public, do not result in damage awards for private parties. Rather, they protect the general public by imposing penalties such as license revocation or incarceration of health-care providers whose behavior imperils public health and welfare. Bad behavior alone, even in the absence of an injury caused by that behavior, can trigger successful criminal or disciplinary actions. This characteristic distinguishes these types of actions from tort actions brought by private parties, who must show behavior plus

²⁸ This characteristic distinguishes these educational practices from the facts of cases such as *Molien v. Kaiser Foundation Hospitals*, 616 P.2d 813, 817 (Cal. 1980) (illustrating a situation where defendant undertook and breached a duty of reasonable care to plaintiff-husband by negligently misdiagnosing his wife as suffering from syphilis), and *Johnson v. State*, 334 N.E.2d 590, 593 (N.Y. 1975) (describing an instance where a hospital assumed and breached a duty of reasonable care to a patient's daughter by informing the daughter that her mother, who was in fact alive and well, had died). Moreover, the absence of contemporaneous observation or awareness of harm sustained by a living loved one distinguishes these educational practices from the facts of "bystander" cases, such as *Dillon v. Legg*, 441 P.2d 912, 925 (Cal. 1968) (holding that a mother who witnessed the negligently caused death of her child was entitled to pursue damages for negligent infliction of emotional distress from defendant driver).

²⁹ The negligence state-of-mind criterion – that emotional distress should have been foreseeable to the reasonably prudent person in the defendant's position – may be easier to establish than an intent to cause emotional distress (or recklessness with regard to its occurring). Foreseeability of a potential outcome, however, while necessary to a finding of liability, is by no means sufficient.

actual harm in order to prevail. Accordingly, in the criminal prosecution and professional disciplinary realms, authorities may target potentially harmful, as well as actually harmful behavior. For example, a professional who practices while impaired by alcohol or drugs may be prosecuted, or disciplined, even if she was sufficiently fortunate to have avoided injuring a patient during the period of impairment. The somewhat broader potential scope of actions brought to protect the public interest, however, should not extend to this field. Educational practices, the intent and impact of which produce only a benefit to the public, ought not to be scrutinized, or punished via disciplinary or criminal proceedings.³⁰

C. Autonomy after Death?

1. Does Autonomy Survive Death?

That individual autonomy survives death, or survives death to an extent sufficient to make autonomy an important factor in this debate, is doubtful. Moreover, allowing the autonomy mantra to drive the results of this discussion is ill advised. But, assuming for the sake of argument that some fragment of the autonomy interest of "[e]very human being of adult years and sound mind"³¹ lingers after his death, this fragment cannot possibly be more substantial than the autonomy interest possessed by the living ancestor of the newly dead body. And as virtually every court to discuss the issue has reminded us, a living individual's interest in autonomy is by no means absolute.³² Courts regularly balance the individual interest in autonomy against various societal interests, including those of other living people.³³ In so doing, courts acknowledge the possibility that societal interests may outweigh individual rights. Accordingly, should we reach the questionable conclusion that an autonomy interest inhering in a newly

³⁰ Criticism aimed at disciplinary authorities suggests that they are more than fully occupied with attempts to prevent potential harm to living patients. See SIDNEY M. WOLFE ET AL., PUBLIC CITIZEN'S HEALTH RESEARCH GROUP RANKING OF THE RATE OF STATE MEDICAL BOARDS' SERIOUS DISCIPLINARY ACTIONS, 2004-2006 (2007) <http://www.citizen.org/publications/release.cfm?ID=7525>.

³¹ *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914); see also *In re Storar*, 420 N.E.2d 64, 70-71 (N.Y. 1981) (finding that an unconscious patient's autonomy interest is preserved).

³² This is true whether the individual's decision-making capacity is intact, questionable, or absent at the relevant time.

³³ For example, living people may include innocent third parties, such as children of a parent who refuses life-saving medical treatment, or people at risk of injury because of the behavior of a mentally ill individual who is dangerous.

dead body is germane to this discussion, the only deference due that interest is to assess its weight relative to the communal and societal interests courts routinely consider when they determine the fates of living individuals.³⁴ Of those societal interests, three appear particularly relevant here: (1) preserving life, (2) protecting third parties, and (3) safeguarding the ethical integrity of the medical profession.³⁵

2. The Balancing Test Applied

Assume that autonomy survives death, and that the newly dead individual had previously declined to have his body serve as an educational resource. An application of the existing balancing test readily produces sufficient support for overriding his wishes because greater weight lies on the side of the relevant societal interests. The societal interest in preserving life, which, not surprisingly, almost always counters the individual autonomy interest in the treatment-refusal cases that spawned this balancing test, similarly weighs against autonomy here.³⁶ The societal interest in preserving life can be furthered only by using, and not at all by abandoning, the educational opportunity afforded by a newly dead body. No life remains to be preserved in the newly dead body, but the preservation of life in general may be fostered, and certainly will not be hindered by taking advantage of the opportunity.

Exploration of the societal interest in protecting third parties commonly occurs in cases in which an "innocent" minor child may be left orphaned if medical professionals or the courts honor a parent's rejection of medical recommendations. But the law must also attend to other situations in which an individual's exercise of autonomy puts third parties at potential risk. For example, third parties may be exposed to a contagious disease when an infected individual thwarts or refuses a public-health intervention. Or third parties may be threatened with violence when a mentally ill and dangerous individual avoids, or rejects, mental-health treatment. Legal measures available for protecting third parties from the damaging consequences of an-

³⁴ See, e.g., *Satz v. Perlmutter*, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980) (expressing that the individual's right to refuse medical treatment is balanced against the state's interest in "the preservation of life[, the n]eed to protect innocent third parties[, the d]uty to prevent suicide[,] . . . [and the duty to] help maintain the ethical integrity of medical practice").

³⁵ A fourth item routinely included in the litany of state interests is the prevention of suicide, which is inapposite here.

³⁶ While the discussion of this interest may focus on preservation of a single identifiable life in a treatment-refusal case, the societal interest in preservation of life extends beyond the individual and embraces human life in general.

other's exercise of autonomy include: court orders to override refusals of treatment, public health acts to implement quarantines, and public or private attempts to cause the involuntary civil commitment of dangerous individuals. Each of these measures interferes with, or may even completely override, an individual's exercise of autonomy.

As reflected in case law and statutes, the interest in safeguarding the ethical integrity of the medical profession is primarily the interest securing a physician's right to "just say no" when asked to cooperate in an activity she finds ethically repugnant. Such an activity need not be illegal. For example, performing an abortion, or discontinuing life-sustaining treatment are activities a physician might shun. Even where an activity is of questionable legality, for instance, participation in active euthanasia, a physician's "conscience" objection furnishes an independent basis for her unwillingness to become involved. Nothing suggested here, however, conflicts with the societal interest in safeguarding the medical profession's ethical integrity. A trainee who is genuinely ethically offended should simply not partake in the educational activity. But if, as I suspect, flawed legal reasoning is the real source of the trend toward condemning these activities, the societal interest in preserving the medical profession's ethical integrity is not even pertinent, let alone in any jeopardy.

3. Beyond the Balancing Test

Health-care professionals often make and carry out decisions beneficial to one patient at the expense of another, and no criticism of those actions should be inferred from this observation. Collectively, whether consciously or not, we have put health-care providers in this position. We expect them, indeed, we rely on them to decide who is sacrificed and who is saved.

In some situations, we label their actions "triage" and understand that necessity drives those actions. Too few resources are available to meet too great a need. So the most salvageable of the critically injured come first when time, provisions, and personnel are in short supply. Moreover, when the intensive-care unit is full and a newly admitted, very sick patient needs an intensive-care bed, someone must be moved to a lower level of care. A physician, or sometimes a nurse, will choose the someone.

In other situations, we label the process "allocation of resources," where, for example, we acknowledge that more people need liver transplants than there are suitable livers to go around. Medical criteria identify who among the patients on the waiting list will receive the

next available liver. In addition, we facilitate medical research using patients enrolled as subjects without their knowledge or consent.³⁷ Inherent in any medical research study is a lack of knowledge about whether participation will help its subjects; it may be that future patients turn out to be the only beneficiaries. Finally, we support the trend toward identification and use of “cost effective” treatments, by which we hope to produce a collective benefit despite the possible detriment to isolated individuals.

All of this nonconsensual activity, undertaken by health-care professionals at our behest, affects living, vulnerable people. To treat the interests of the newly dead as sacrosanct and entitled to absolute protection, when the interests of those currently alive are not so treated, is absurd.

III. A MODEST PROPOSAL ENCOURAGING APPROPRIATE USE OF EDUCATIONAL RESOURCES

A. The Proposal

Minimally invasive educational practices using newly dead bodies are not illegal, and should not be made illegal. Performing them defensively, or with subterfuge, which simply reinforces the impression that they are “wrong,” is ill-advised.

In a couple of decades, the hopeful estimate of the amount of time it will take for technology to make the issue moot, the need for these activities may be obviated by the widespread availability of virtual reality programs, and sufficiently sophisticated and affordable mannequins. If so, then this issue will simply go away. In the meantime, ensuring that professionals continue to be well prepared is of paramount importance. My narrow and modest proposal, then, is to say “yes!” to the question posed at the beginning of this article, with the understanding that the population of eligible teaching subjects is limited by the terms of the anecdote, as explained in greater detail below.

Not all people who seek health care in emergency-room settings do so because their need is critical, or even urgent. Sometimes people visit an emergency room because they feel ill and have no other place to go. This article does not encompass those folks, however. My use of the term Emergency Care is intended to capture two essential aspects of certain health-care services: that they are 1) provided in the emergency room, and 2) required to treat or stabilize a condition that

³⁷ See 21 C.F.R. § 50.24 (2007) (allowing an “[e]xception from informed consent requirements for emergency research”).

poses an imminent risk of death or significant disability if not attended to immediately. Under this definition, the patient described in the anecdote at the beginning of this article received Emergency Care. In contrast, a person with a cough and fever who comes to the emergency room on Saturday night rather than wait for his physician's office to open on Monday morning does not receive Emergency Care as discussed in this article, even if an emergency-room physician diagnoses his bronchitis and prescribes treatment.

The rationales may be summarized quickly. As discussed in Part II above, the analogy to consent requirements for organ procurement is inapt, loved ones' legitimate interests can be fully protected, and in the unlikely event that autonomy survives death, it must yield to the superior interests of others who are still alive. Finally, as I explore in detail below, Emergency Care is different from care provided in other circumstances.

This proposal embraces only those "newly dead" bodies that to all reasonable appearances have not been the victims of violent crimes, so that there are no death investigation implications, and about which no ambiguity exists concerning the diagnosis of death, so that no need exists to confirm that all neurological diagnostic criteria are met. And *all* who die in, or who are dead on arrival at the emergency room should be included in this population. This means that neither the decedent, nor the decedent's next-of-kin can, or should be given the chance to opt out.

B. Why Emergency Care?

Why should Emergency Care cases supply the bodies for this educational objective? Several significant attributes of Emergency Care suggest justifications. Emergency care is **different**. Anyone and everyone – indigent or wealthy, insured or uninsured, male or female, young or old, chronically ill or generally healthy, privileged or deprived – can end up in the emergency room. This factor alone goes far toward ensuring that the "selection of subjects is equitable,"³⁸ a criterion important to maintaining confidence that no group bears a disproportionate share of this burden.

Emergency Care rescues, or offers hope of rescue, to those facing dire and immediate threats because of trauma, or sudden serious illness. It does not prevent, or offer hope of prevention, which distinguishes it from primary health care services. Emergency Care is, at least theoretically, available to all without regard to source of pay-

³⁸ 45 C.F.R. § 46.111(a)(3) (2006) (stating one of several criteria for approval of research on living human subjects).

ment, or indeed, ability to pay. For many years, the law has treated Emergency Care as though it is special and ought to be accessible to those in need. Courts, legislatures, and regulatory agencies have all used their lawmaking power and authority to encourage, and even force, the ready availability of Emergency Care.

1. Courts and Emergency Care: Tort Liability

Among the criteria a plaintiff pursuing a negligence claim must establish is that the defendant owed the plaintiff a duty of reasonable care. The general principle governing questions of duty is that by undertaking an activity, one undertakes a duty of reasonable care toward those who are reasonably foreseeably affected by that activity. This standard readily allows for satisfaction of the duty criterion when applied in many health-care negligence cases. The reason is that the defendant, whether a professional or an institution, will have undertaken to diagnose or treat the patient/plaintiff, thereby undertaking a duty of reasonable care toward him. In such cases, the alleged act of negligence or malpractice that prompts the lawsuit will have occurred after establishment of the treatment relationship. Moreover, whether an act of negligence or malpractice actually took place, that is, whether there was a breach of a recognized duty, is generally much more hotly debated by the parties than the question whether a duty existed in the first place. The same generalization cannot be made about negligence claims arising out of emergency-room incidents. In those cases, the injury is just as likely to result from a failure to provide treatment as from an affirmative act of negligence or malpractice. This means that two of the legal criteria a plaintiff pursuing such a negligence claim must establish, the existence of a duty of reasonable care and the failure to fulfill that duty, revolve around the same event -- the failure to provide any treatment at all. But only if a duty of reasonable care exists in the first place could the failure to provide treatment constitute actionable negligence. Without a duty of reasonable care, the failure to provide treatment, even if in some sense "unreasonable,"³⁹ would not constitute actionable negligence. In short, the plaintiff in such a situation is not able to rely on a preexisting provider-patient relationship as the predicate for a finding that the defendant owed him a duty of care.

³⁹ For example, the failure to provide treatment may be "unreasonable" if providing treatment would conform to the standard of care and would not be unduly burdensome.

At least since the landmark decision in *Wilmington General Hospital v. Manlove*,⁴⁰ however, courts have treated denials of emergency-room treatment differently for purposes of duty analysis. Although the *Manlove* court acknowledged that a hospital “is under no legal obligation to the public to *maintain* an emergency ward,”⁴¹ it made clear that a hospital’s refusal to provide emergency care when a patient has relied on its “well-established custom” to render such aid, may form the basis for negligence liability. According to this line of reasoning, an institution undertakes such action by operating an emergency room, thereby inviting those in need of emergency care to rely on that undertaking by seeking treatment. Once the relying patient seeks treatment, the duty criterion of negligence law is fulfilled, so that the institution operating the emergency room has assumed a duty of reasonable care toward the patient. This approach, rooted in *Manlove*, and developed more fully in later cases, provides someone injured by a mere *denial* of emergency care a credible basis for a claim. The specter of such liability, along with the legislative mandates discussed below, has created the incentive for institutions to change certain practices so that they also treat emergency care differently.

2. State Legislatures and Emergency Care: Licensing Statutes

Hospitals, like individual health-care professionals, must be licensed by the states in which they provide health care, and state legislatures often attach conditions to the procurement and maintenance of health-care providers’ licenses.⁴² Commonly included among such conditions in hospital licensing statutes are provisions creating and defining hospitals’ emergency-care obligations. A hospital that runs afoul of such provisions may find itself in trouble with the agency that governs its licensure and operations. A hospital that runs afoul of such provisions and causes personal injury in doing so may find itself facing a plaintiff armed not only with a common-law negligence claim, but also with a claim based on the violation of a statute intended to protect individuals like him from precisely the sort of harm he sustained. The Arizona Supreme Court, for example, bolstered the *Manlove* common-law analysis with the familiar tort law adoption of a statutory violation to allow the imposition of liability on institutions

⁴⁰ 174 A.2d 135 (Del. 1961).

⁴¹ *Id.* at 139 (emphasis added).

⁴² *E.g.*, CAL. HEALTH & SAFETY CODE § 1317 (West 2000); N.Y. PUB. HEALTH LAW § 2805-b(2) (McKinney 2007).

whose refusals of emergency care cause physical harm to specific patients.⁴³

3. Congress and Emergency Care: EMTALA, the “Anti-Dumping” Statute

Congress, not to be excluded from the recognition that emergency care is different, included provisions in the Emergency Medical Treatment and Labor Act (EMTALA) of 1985.⁴⁴ Congress’s goal, discouraging private hospitals from “dumping” indigent patients, coincided with state legislatures’ goals. But EMTALA reaches well beyond that goal. Because EMTALA creates an obligation implemented and enforced as a “condition of participation” in the Medicare program, it is both potent and comprehensive. EMTALA’s potency lies in its link to Medicare: eligibility to receive Medicare payments is essential to the financial survival of most hospitals in the United States. The ultimate sanction for an institution that fails to comply with Medicare’s conditions of participation is exclusion from the Medicare program, and accordingly, a loss of Medicare revenue. EMTALA’s comprehensiveness lies in its choice of beneficiaries: all who come to the emergency room are protected by EMTALA’s requirements, and anyone injured by a violation of EMTALA may pursue a private claim for relief on that basis. Despite the source of the EMTALA rule and the impetus for enacting it, the injured party need not be a Medicare beneficiary, or an indigent or uninsured individual.⁴⁵

4. So: Why Emergency Care?

The multifaceted effort to ensure access to Emergency Care both derives from, and illustrates a broadly supported view that emergency care is different; that in a crisis posing an imminent threat of death or serious injury, characteristics that otherwise distinguish us from one another become insignificant because of the exigent circumstances. We all benefit from this view – because when we come to the emergency room, we may be unconscious, unaccompanied, unidentified, or otherwise unable to help ourselves. It is precisely when we are at our most vulnerable that our need will be greatest. None of us knows

⁴³ *Guerrero v. Copper Queen Hosp.*, 537 P.2d 1329, 1331 (Ariz. 1975).

⁴⁴ See SCOTT BECKER, *HEALTH CARE LAW: A PRACTICAL GUIDE* § 21.01(2)(b) (2d ed. 1998) (offering an overview of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)).

⁴⁵ The commentary about EMTALA is voluminous. For a concise summary of the statute’s requirements, see *id.* § 21.01(2)(c).

when, or whether, we will find ourselves in such circumstances, but we all know that the law puts us on an equal footing with our peers should the worst happen.

We all benefit, and therefore we should all have equal opportunity to bear a small part of the burden. We should all have an equal chance to participate in the educational activities by which the next generation of professionals learns the skills to treat the next generation of the ill and injured. Making everyone eligible to help in bearing this burden, with continued regard for the death-investigation concerns surrounding crimes, eliminates the potential for maldistribution of burden that has been observed in other contexts, where the poor or uninsured have been the principal source of research or teaching subjects.⁴⁶ This means that neither the decedent nor the decedent's next-of-kin can, or should be given the chance to opt out. The *quid pro quo* for coming to the emergency room, taking advantage of the haven and rescue it may offer in a crisis, is to cooperate in furthering the mission of the institution that makes the potential rescue possible, at least when that cooperation cannot cause harm.

C. Guidelines

Institutional or professional guidelines to govern these practices should incorporate a spirit of respect for subjects, and maintain a focus on educational goals. Three principles seem critical to setting appropriate boundaries.

1. Limit Practice Opportunities to Those Who Must Develop Particular Skills.

A physician pursuing a pediatric residency must compile a skill set different from that of an aspiring dermatologist or a future specialist in emergency medicine. Teach only those who need to learn; all physicians need not be able to perform a pericardiocentesis, or insert a central venous line. Indeed, a nurse training to practice as a certified registered nurse anesthetist has a greater need than many physicians to become proficient at inserting central venous lines.

⁴⁶ See Wilson, *supra* note 14, at 248-49 & nn.53-60.

2. Limit Practice Opportunities to Occasions When a Preceptor or other Skilled Teacher is Available to Supervise and Critique the Novice.

While opportunities should not be squandered, neither should they be abused. A novice who attempts to perform a procedure without being observed by, and receiving prompt feedback from, a skilled preceptor is just as likely to form the basis for a bad practice as to learn how to perform a procedure properly.

3. Limit Practice Opportunities to Those Already Trained on Mannequins, Human Performance Simulators, or Virtual Reality Simulators.

Again, while opportunities should not be squandered, neither should they be abused. Novices should always undergo appropriate classroom and simulation training prior to attempting a procedure using a human body, living or dead.

Additional considerations may help to create sensible and tolerable guidelines, several of which are suggested below. Adhering to any of them will reduce the available educational opportunities but will also minimize the invasion perceived by some objectors. First, limit practice opportunities to replication of procedures performed during the attempt to resuscitate or otherwise rescue the subject. For example, only if a central venous line was inserted during the treatment phase should a novice practice such an insertion. Second, limit practice opportunities to one attempt each at whatever procedures are practiced. Next, limit practice opportunities to one novice for each newly dead body. Last, limit practice opportunities to a specific amount of time, so as to ensure an absolute time limit between the declaration of death and the cessation of post-mortem practice procedures.

CONCLUSION

Every medical professional who will ever perform a procedure on a human being must perform each procedure a “first time.” Using a newly dead body for such an initial performance cannot do it any harm. Accordingly, routine use of newly dead bodies for teaching novices helps to ensure conformity with the age-old “first” principle of medical ethics: “First, do no harm.”

